(b) Check the beneficiary eligibility or history file if the claim does not reveal any discrepancy and remail the original EOB, EOB and check or development letter with the new address if one is found.

(c) If the efforts listed above do not result in a different address or name, no further action is required. The EOB or development letter may be destroyed, and, if a check is attached, the check should be voided. Any claim being held pending response to the development letter may be processed to completion at this point even though the 35-day development period may not have elapsed.

(2) When a beneficiary's EOB or EOB and check is returned as undeliverable due to "addressee deceased," the contractor shall verify that the EOB was addressed correctly or whether it should have been issued to the beneficiary's estate or next-of-kin and remail with corrected information, if appropriate. The contractor will develop for an appropriate payee if the beneficiary is deceased. (See Section VI.H.6.f. below.) The EOB shall be destroyed, if no new information can be found. The check should be voided.

g. Procedures for Handling Returned Provider EOBs and Summary Vouchers

When provider EOBs or summary vouchers are returned as undeliverable, the contractor shall:

(1) Review the EOB or summary voucher for accuracy against the provider file and against the claims(s) if the provider file does not reveal any inconsistencies.

(2) Contact the appropriate state licensing agency for the correct address if the above research is unsuccessful.

(3) Remail the EOB or summary voucher within five (5) days of its return when a new address is obtained. (Correct the provider file as appropriate.)

(4) If the above efforts do not result in a different address or name, no further efforts to obtain a correct name or address are required. The EOB may be destroyed and any check should be voided.

h. Procedures for Handling Undeliverable Checks (with or without EOBs)

Procedures for handling undeliverable checks are discussed in Section VI.H.6.f. above. The contractor's *TRICARE* claims department shall be responsible for researching the correct address and shall follow the procedures in Section VI.H.6.e. through Section VI.H.6.g. above. Additional research must be performed when the check is undeliverable because the addressee is deceased. Contractors must attempt to determine the next-of-kin for a beneficiary by checking the beneficiary eligibility/history file and the claim. When the next-of-kin is identified, the contractor shall send a letter requesting information to enable payment to the legal representative of the estate. If a next-of-kin is not identified, the letter shall be addressed to the estate of the beneficiary at the last known address. (See Section IV.F.1.d., for procedures for payment of claims of deceased providers and applicable state laws.)

I. Claims Splitting

As a general rule under HCSRs, claims should not be split (unless otherwise indicated) but should be reported using the same ICN with a different suffix. Single claims may be split in accordance with the following rules:

HCSRS	1. A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under HCSRs for different beneficiaries.
HCSRS	2. A claim for the lease/purchase of durable medical equipment that is paid by separately submitted monthly installments will be split into one claim for each monthly installment. The monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. Must be split under HCSRs.
HCSRS	3. A claim that contains services, supplies or equipment covering more than one *contractors* jurisdiction shall be split. The claim and attached documentation shall be duplicated in full, and identification shall be provided on each document as "processed" by the *contractor* and then mailed to the other appropriate *contractor* having jurisdiction. The *contractor* splitting the claim counts the remaining material as a single claim, and the *contractor* receiving the split material for its jurisdiction, counts it as a single claim, unless the split material meets one or more of the other criteria for an authorized split.
HCSRS	4. A claim that contains more than $999,999.99 may be split. This includes DRG claims with submitted charges exceeding $999,999.99.
HCSRS	5. An inpatient maternity claim which is subject to the TRICARE DRG-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the Policy Manual, Chapter 11, Section 5.1.
HCSRS	6. A claim with procedures which require an ONAS as well as procedures which do not require an ONAS shall be split, because there will be both institutional and noninstitutional services.
HCSRS	7. A claim submitted with both inpatient and outpatient services requiring both inpatient and outpatient Nonavailability Statements may be split, because there would be both institutional and noninstitutional services.

HCSRS	8. Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT codes) shall be reported on a noninstitutional format. See the Policy Manual, Chapter 13, Section 22.1D.
HCSRS	9. A claim submitted on behalf of a nonparticipating provider with dates of service on and after November 1, 1993, shall be multi-suffixed to account for the balance billing limitation based upon the dates of service effective with processed to completion date on or after November 1, 1993.
HCSRS	10. A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for (1) charges for services which are included in the prospective group payment rate, (2) charges for services which are not included in the prospective group payment rate and are separately allowable, and (3) physician's fees which are allowable in addition to the facility charges. (See the Policy Manual, Chapter 13, Section 9.1.)

J. Liver Transplant Claims

Benefits are payable for liver transplantation when the service meets the requirements specified in the Policy Manual, Chapter 3, Section 8.5. Provider and reimbursement requirements are also included in the Policy Manual.)

K. Heart Transplant Claims

Benefits are payable for heart transplantation when the service meets the requirements specified in the Policy Manual, Chapter 3, Section 5.3. (Provider and reimbursement requirements are also included in the Policy Manual.)

L. Former Spouses with Pre-Existing Conditions

The former spouse will be coded as ineligible on DEERS. A Memorandum of Authorization issued by the military service must be attached to the claim to provide the period of eligibility and identify the specific pre-existing condition for which *TRICARE* benefits are authorized. If the Memorandum of Authorization is attached, the contractors shall override the DEERS eligibility response and the INAS and ONAS requirements and process the claim. If the Memorandum of Authorization is not attached, the claim shall be denied as eligibility expired on DEERS. Refer to Policy Manual, Chapter 9, Section 1.1A and 1.1B.

M. Hospice Programs

On a one time basis, contractors shall notify, by letter, all hospice programs certified to participate in Medicare, of the implementation of a hospice benefit under *TRICARE* (i.e., those hospice programs appearing in the October 3, 1994, Medicare Report,

see Policy Manual, Chapter 13, Addendum 4, Exhibit 2). A sample letter is provided at Figure 2-1-A-22. Contractors shall offer the Medicare approved programs the opportunity to become certified by signing the Participation Agreement for Hospice Program Services (see Policy Manual, Chapter 13, Addendum 4, Exhibit 1). Thereafter, the contractors shall follow the guidelines in the Policy Manual, Chapter 13, Section 22.1C for certification of hospice programs.

N. Procedures For Contractor Coordination On Out-of-Jurisdiction Providers

Contractors subject to the requirements of the Automated Data Processing and Reporting Manual (OCHAMPUS 6010.50-M) who are responsible for processing claims for care provided outside of their provider certification jurisdiction (i.e., claim processing jurisdiction is determined by beneficiary residence or jurisdictions based on beneficiary residence and provider location overlap) shall first search available provider files, including the *TMA*-supplied copy of the *TRICARE* centralized provider file (to be provided at least weekly), to determine provider certification status, obtain related provider information, and determine if the certifying contractor has submitted a Health Care Provider Record (HCPR) for the out-of-area provider.

1. File Search Unsuccessful

If the file search is unsuccessful, the following procedures apply:

a. The servicing (claims processing) contractor shall request provider information from the certifying contractor and put the claim in controlled development status at the time of the request (e.g., date of telephone contact, fax, etc.).

b. Each contractor shall designate a point of contact as specified in this chapter at Section II.A. who shall be responsible for initiating actions related to such requests and ensuring these actions are timely and well documented.

c. The certifying contractor shall respond within two workdays of the request with either a.) complete provider information for the servicing contractor to process the claim and submit a Health Care Service Record (HCSR) in situations when a HCPR has already been accepted by *TMA* or b.) the information that a HCPR for the provider in question has not been submitted to or accepted by *TMA* and one of the following situations exist:

(1) The certifying contractor has sufficient documentation (including the provider's TIN) to complete the certification process and determine the provider's *TRICARE* status; or

(2) The certifying contractor does not have sufficient documentation to determine the provider's status and complete the certification process; or

(3) The certifying contractor has sufficient information to determine that the provider does not meet *TRICARE* certification requirements without going through the certification process; or

(4) Situations 1., 2., or 3. above apply, but the certifying contractor is not subject to the requirements of the Automated Data Processing and Reporting Manual.

2. HCPR Submission

Since the servicing contractor will be unable to complete HCSR processing until a HCPR is accepted by *TMA*, a coordinated effort is required between the servicing contractor and the certifying contractor in the above situations. The certifying contractor is responsible for ensuring the HCPR is accepted by *TMA* before supplying the provider information indicated at Section VI.C.6. of this section. Contractors should not delay submitting HCPRs for providers who have requested certification and such certification has been granted or denied, solely because the provider has not yet submitted a *TRICARE* claim. When the HCPR is accepted, the certifying contractor shall notify the servicing contractor of this within two workdays of its acceptance and supply the provider information. Following are procedures and time frames to facilitate this coordination.

a. If the certifying contractor has completed its provider certification process but has yet to submit the HCPR (or clear the HCPR through the *TMA* edits), the certifying contractor shall submit (or resubmit) the HCPR within one workday of contact by the servicing contractor and notify the servicing contractor within two calendar weeks following the initial contact, of the HCPR submission action taken and whether the HCPR has been accepted.

b. If the certifying contractor does not have sufficient documentation to complete the certification process and submit a HCPR, the certifying contractor shall initiate (or follow up on) the certification process within two workdays of the initial contact by the servicing contractor. If it is necessary to obtain documentation from the provider, the certifying contractor shall allow no longer than a two calendar week suspense from the date of its request. This is an exception to normal controlled development requirements.

(1) Upon determination that the documentation is complete, the certifying contractor shall complete the certification process, submit the HCPR, and notify the servicing contractor within one additional calendar week following completion of the certification process (i.e., within three weeks of the initial contact by the servicing contractor). The certifying contractor shall also notify the provider of the certification determination and of procedures for contacting the certifying contractor in the future regarding provider-related (nonclaim) matters (e.g., address changes).

(2) If the certifying contractor is unable to complete the certification process within three calendar weeks following the initial contact, it shall submit the HCPR and notify the servicing contractor within four calendar weeks following the initial contact.

(a) If the certifying contractor has substantial evidence (e.g., state licensure listing) that the provider meets *TRICARE* certification requirements, it shall consider the provider certified and so inform the servicing contractor one work day after acceptance.

(b) If the certifying contractor does not have substantial evidence that the provider meets *TRICARE* certification requirements, it shall not consider the provider to be certified. The servicing contractor shall deny the claim and report the message "Provider certification status not documented" on the EOB.

(c) In either of the above cases, if the certifying contractor does not have the provider's TIN, it shall submit the HCPR with a contractor Assigned Provider Number (APN) as described in the ADP Manual, Chapter 2, Section X., Provider Taxpayer Number, and provide this number to the servicing contractor. The servicing contractor shall issue payment only to the beneficiary in this case if the claim is otherwise payable (even in the unlikely event that the provider is participating).

(d) If, at the time of the servicing contractor's initial contact, the certifying contractor is able to determine that the provider does not meet the *TRICARE* certification requirements without going through the certification process, it shall submit the HCPR and notify the servicing contractor within two calendar weeks of the initial contact. If the provider's TIN is not known, the certifying contractor shall assign an APN. The servicing contractor shall deny the claim and report the message "Provider not *TRICARE*-authorized for this service" on the EOB.

(e) If the certifying contractor is not subject to the requirements of the Automated Data Processing and Reporting Manual, the servicing contractor will assign the provider sub-ID and create the HCPR. The certifying contractor shall provide the servicing contractor with the minimum provider information listed in Section VI.N.2.d. below, within two workdays of the initial contact by the servicing contractor if the certification process has been completed or if a determination can be made that the provider does not meet the certification requirements without going through the process. If it has not been completed, the servicing contractor shall be so notified within two workdays of the initial contact and the procedures and time frames in Section VI.C.2. above shall be followed.

c. The servicing contractor shall notify the *TMA* Contracting Officer's Representative if the certifying contractor does not provide the required provider information and notification of the HCPR's acceptance by *TMA* within 35 calendar days from the time of the initial contact.

d. The minimum provider data to be provided by the certifying contractor is the provider's certification status including the reason a provider is not certified if such is the case, any special prepayment review status, and the following HCPR data:

(1) Provider Taxpayer Number or Assigned Provider Number

(2) Provider Sub-identifier (may need to be assigned by the servicing if the certifying contractor is not on HCSRs)

(3) Provider Contract Affiliation Code

(4) Provider street address

(5) Provider "pay to" address

(6) Provider State or Country

(7) Provider Zip Code

(8) Provider Specialty (noninstitutional providers)

(9) Partnership data (Partnership indicator, discount percentage, effective and ending dates)

(10) Type of Institution (institutional providers)

(11) Type of reimbursement applicable (DRG, MHPD, etc.)

(12) Per diem reimbursement amount, if applicable

(13) IDME factor (where applicable)

(14) Provider Acceptance Date

(15) Provider Termination Date

(16) Record Effective Date

e. The certifying contractor shall provide additional data upon request of the servicing contractor or *TMA* to meet internal processing, prepayment review, or file requirements or, to create a HCPR when the certifying contractor is not under the requirements of the Automated Data Processing and Reporting Manual. The certifying contractor shall also provide the pricing information and any special provider reimbursement arrangements (e.g., Partnership) for the servicing contractor to accurately determine the allowable amount for the provider's services if the provider is *TRICARE* certified.

f. Maintenance of HCPR with an Assigned Provider Number (APN)

g. In all cases when an APN is assigned, the certifying contractor shall attempt to obtain the provider's actual TIN. Within ten workdays of receipt of the provider's TIN, the certifying *contractor* who is under the requirements of the Automated Data Processing and Reporting Manual shall inactivate the APN HCPR and add the HCPR with the provider's TIN regardless of whether the provider meets *TRICARE* certification requirements.

h. Provider Correspondence

i. Any provider correspondence which the servicing contractor forwards for the certifying contractor's action or information shall be sent directly to the certifying contractor's point of contact to avoid misrouting.

j. Within one week of receipt, the servicing contractor shall forward for the certifying contractor's action any correspondence or other documentation received which indicates the need to perform a provider file transaction. This includes, but is not limited to, such transactions as address changes, adding or deleting members of clinics or group practices, or changing a provider's TIN.

k. Provider Certification Appeals

l. Requests for reconsideration of an contractor's adverse determination of a provider's *TRICARE* certification status are processed by the certifying contractor. Any such requests received by the servicing contractor are to be forwarded to the certifying contractor within five workdays of receipt and the appealing party notified of this action and the reason for the transfer. The certifying contractor shall follow standard appeal

procedures including aging the appeal from the date of receipt by the certifying contractor, except that, if the reconsideration decision is favorable, the provider shall be notified to resubmit any claims denied for lack of *TRICARE* certification to the servicing contractor with a copy of the reconsideration response. In this case, the certifying contractor shall ensure a HCPR for this provider is accepted by *TMA* within one calendar week from the date of the appeal decision.

m. The servicing contractor shall forward to the certifying contractor within five workdays of receipt any provider requests for review of claims denied because the certifying contractor was unable to complete the certification process. The servicing contractor shall notify the provider of the transfer with an explanation of the requirement to complete the certification process with the certifying *contractor.* Upon receipt of the provider's request, the certifying contractor shall follow its regular *TRICARE* provider certification procedures. In this case, no basis for an appeal exists. If the provider is determined to meet the certification requirements, the special provider notification and HCPR submittal requirements in Section VI.N.2.l. apply.

Figure 2-1-A-12 Abortion Denial Notice to the Beneficiary and Participating Provider (Continued)

If you have any questions concerning the CHAMPUS abortion policy, you are urged to contact your Health Benefits Advisor (located at the nearest Uniformed Services medical facility) for more detailed information. You may also contact ***(Contractor Name and Address.)***

Sincerely,

Figure 2-1-A-13 Suggested Format for Information Obtained from Existing File Data or by Telephone

Date Information Obtained: _____

Beneficiary Name: _____

Sponsor Name: _____

Internal Control Number (ICN): _____

Source of Development: ☐ Existing File Data

Check one block **only** and complete blank below that block).

Name of file or ICN of previously processed claim if data is claim specific _____

☐ Telephone

Name of Person Providing Information

_____

Type of Claim:

☐ Claim Form 2520 ☐ Claim Form 1500 ☐ UB-92 ☐ Other

Item Completed _____ ***(Information Obtained)*** _____

_____

Initials or Signature of Person Obtaining Information

THIS DOCUMENT IS TO BE MICROFILMED OR IMAGED AS PART OF THE CLAIM RECORD *(THIS DOCUMENT MAY ALSO BE MAINTAINED ON AN ELECTRONIC RECORD). SEE THE OPM PART TWO, CHAPTER 1, SECTION V.B.2.B.*

Privacy Act Statement:

In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55, Title 10, United States Code, Section 3101, Title 44, United States Code, and 41 Code of Federal Regulations 101-1100 ***et seq****. The information is requested to establish or update information to control or process claims for payment. Routinely, the information will be used to determine eligibility for CHAMPUS benefits, review and approve medical care as CHAMPUS benefits, and to determine reasonable charges/costs of care to be cost-shared under CHAMPUS. Disclosure of the information is voluntary; however, failure to provide the information will result in denial of benefits.*

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II. TYPES OF PROVIDERS

A. Institutional Providers

1. Institutional providers are those providers which primarily provide inpatient care to the ill and the infirm and which are other than professional corporations or professional associations. Institutional providers (hospitals, skilled nursing facilities, nursing homes, etc.) bill for services, both inpatient or outpatient, in the name of an organization. The term "institutional provider" does not include a professional corporation or a professional association qualifying as a domestic corporation under Section 301.7701-5 of the Federal Income Tax Regulation nor does it include other corporations that provide principally professional services.

2. The Contractor is the *TRICARE* certifying authority and, accordingly, may grant *TRICARE*-authorized institutional provider status to the following categories of institutional providers which are Medicare-certified, JCAHO-accredited (when required), and that facility meets all criteria for its provider category required by *32 CFR 199.6.* The Contractor shall keep informed as to the Medicare certification and JCAHO accreditation (when required) of each institution within its jurisdiction to assure that institutions maintain their *TRICARE*-approved provider status. This requires a regular review of the accreditation and certification directories at Figure 2-2-A-1 of this chapter and by any other inquiry as the Contractor deems necessary to assure that only eligible facilities receive *TRICARE* reimbursement.

a. Christian Science Sanitariums

b. Heart Transplant Centers

c. Liver Transplant Centers

d. Free Standing Ambulatory Surgical Centers

e. Birthing Centers

f. Hospitals - General, acute, long term, psychiatric (inpatient), and special (e.g., rehabilitation)

g. Infirmaries

h. Skilled Nursing Facilities

3. For hospitals that do not have JCAHO accreditation, the Contractor may waive the JCAHO accreditation for any of the above institutions except psychiatric hospitals (inpatient and partial), and substance use disorder rehabilitation facilities. The Contractor may waive JCAHO accreditation for both network and non-network institutions. The Contractor shall document why the institution does not have JCAHO accreditation, if it has lost its JCAHO accreditation, what date it was terminated, the reason why, and what impact on the program it will have if the waiver is not obtained. If the institution lost its JCAHO accreditation because of an issue of health and safety of the patients, the Contractor shall not grant the waiver. Medicare certification must be maintained. Prior to granting the waiver, the Contractor shall consult with the Lead Agent to determine any reasons why the waiver should not be granted. If the Lead Agent does not agree that the instituition's JCAHO accreditation should be waived and the matter cannot be resolved between the two parties,

the proposed waiver shall be referred to the Director, *TMA*, for a final decision. *In the case of those psychiatric hospitals that are not JCAHO accredited because they have not been in operation a sufficient period of time to be eligible to request an accreditation survey by the JCAHO, the contractor may grant temporary approval if the hospital is certified and participating under Title XVIII of the Social Security Act (Medicare, Part A). This temporary approval expires 12 months from the date on which the psychiatric hospital first becomes eligible to request an accreditation survey by the JCAHO.*

B. Professional/Non-Institutional Providers of Care

1. General

a. Certification Requirements

Professional providers of care are those providers who usually provide direct personal service to patients in the form of evaluating, counseling, surgery and similar personal services and who usually bill for their services on a fee-for-service basis. These are physicians, dentists, podiatrists or other allied health professionals who are not employed by or contracted with an institutional provider (e.g., a hospital, skilled nursing facility, etc.) and who are not employees of another professional provider and providing care which is incident to the care of the employer. Those professional providers who provide direct patient care, independently, even though employed by another professional provider (e.g., a social worker or psychologist, employed by a psychologist or psychiatrist, but who works in counseling with patients) must also be certified. All individual professional providers must be licensed by the local licensing agency for the jurisdiction in which the care is provided; or, if the licensure is not provided by the state, be certified by or be eligible for membership in the appropriate national or professional association which sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms. Any professional who provides direct patient care must be qualified under *TRICARE* standards or, for in-system care only, under contractor standards which have been approved by *TMA*.

b. Billing on Behalf of a Professional Employee or Member

In any instance in which a professional provider, professional corporation or professional association bills on behalf of a professional employee or professional member who requires *TMA* authorization for services, that provider, as part of the certification procedure, must obtain and retain in his/her files authorization for the employer or association to bill for his or her services. The provider must agree to obtain and maintain agreements when a new professional employee or member joins the provider or provider organization and to keep the contractor informed of such changes. Additionally, the provider must agree to make the agreement (or an acceptable copy) available to *TMA*, the contractor or other entity specifically approved by *TMA*, e.g., Defense Audit Agency.

c. Licensing Required: Scope of License

Otherwise covered services shall be cost-shared or paid under *TRICARE* only if the individual professional provider holds a current, valid license to practice his or her profession or is otherwise legally authorized to practice as required in the

jurisdiction where the service is rendered. The service provided must be within the scope of the license or within the scope provided by other legal authorization to practice.

d. Christian Science

Christian Science practitioners and Christian Science nurses are recognized by public law to provide services under *TRICARE*. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services. Practitioners and nurses must be listed or eligible for listing in the **Christian Science Journal** at the time the services are provided.

2. Interns and Residents

Interns and Residents may not be paid directly under *TRICARE* for services rendered to a beneficiary when their services are provided as part of their employment, whether salaried or contractual, by a hospital or other institutional provider.